For families of three persons, including the client and all members of the family residing in the same household:

Adjusted Gross Income Categories *(amount reported by liable party on most recent federal income tax return)*	Fee Factor *(% of the regional center's cost of services provided)*
$1 - $104,999	0%
$105,000 - $109,999	5%
$110,000 - $114,999	10%
$115,000 - $119,999	15%
$120,000 - $124,999	20%
$125,000 - $129,999	25%
$130,000 - $134,999	30%
$135,000 - $139,999	35%
$140,000 - $144,999	40%
$145,000 - $149,999	45%
$150,000 - $154,999	50%
$155,000 - $159,999	55%
$160,000 - $164,999	60%
$165,000 - $169,999	65%
$170,000 - $174,999	70%
$175,000 - $179,999	75%
$180,000 - $184,999	80%
$185,000 - $189,999	85%
$190,000 - $194,999	90%
$195,000 - $199,999	95%
$200,000 and over	100%

For families of four or more persons, including the client and all members of the family residing in the same household:

Adjusted Gross Income Categories *(amount reported by liable party on most recent federal income tax return)*	Fee Factor *(% of the regional center's cost of services provided)*
$1 - $134,999	0%
$135,000 - $139,999	5%
$140,000 - $144,999	10%
$145,000 - $149,999	15%
$150,000 - $154,999	20%
$155,000 - $159,999	25%
$160,000 - $164,999	30%
$165,000 - $169,999	35%
$170,000 - $174,999	40%
$175,000 - $179,999	45%
$180,000 - $184,999	50%
$185,000 - $189,999	55%
$190,000 - $194,999	60%
$195,000 - $199,999	65%
$200,000 - $204,999	70%
$205,000 - $209,999	75%
$210,000 - $214,999	80%
$215,000 - $219,999	85%
$220,000 - $224,999	90%
$225,000 - $229,999	95%
$230,000 and over	100%

For purposes of these fee schedules, members of the family are the liable party and any person declared to be a dependent for purposes of federal income taxes of the liable party.

This sliding fee schedule is based exclusively on income--real or personal property resources are not considered.

The Department of Developmental Services will be responsible for billing and collecting fees assessed in accordance with the fee schedule above. The fee schedules will be adjusted on July 1 of each year based upon the estimated California Necessity Index increase for the State fiscal year for which the adjusted fee schedules will apply. This section shall not be construed to restrict eligibility for, or deny services to, any individual who qualifies for regional center services. That is, failure to pay a fee shall not be a basis for denying services. Liability for fees is in accordance with and subject to the provisions of California Senate Bill 92, a copy which is attached hereto and incorporated herein by this reference.

ATTACHMENT 1

.E OF CALIFORNIA — DDS
AEL: 1988 - TEST FORM 2

CASE MANAGER CODE: 300
CASE MANAGER NAME: WILLIAM THE FRIDGE PERRY

TITLE XIX ACTIVITY LOG
FOR THE MONTH OF DECEMBER 1988

CLIENT NAME: ADDISON DAVID
CLIENT UCI: 4500201
CLIENT MEDI-CAL #: 19609777788E

DAY OF MONTH	ACTIVITY CODE *	NUMBER OF UNITS	CLARIFICATION OF ACTIVITY CODE

TOTAL UNITS:

SIGNITURE OF CASE MANAGER:

ACTIVITY CODES: A = ASSESSMENT P = TREATMENT PLANNING
T = TELEPHONE CLIENT TC = TELEPHONE, COLLATERAL
FV = FIELD/OFFICE VISIT, CLIENT FC=FIELD/OFFICE VISIT, COLLATERAL
R = RECORDING (SEE INSTRUCTIONS FOR GUIDANCE ON CODE AND ACTIVITY USAGE)

Reimbursement Unit of Services

For client data purposes and research, a case management unit of service is defined by DMH as a face-to-face or telephone contact with a client, regardless of the length of time. That contact is documented in the client case management record and, ultimately, reported to the State as part of the Client Data System. For purposes of cost analysis, rate development, and reimbursement, the case management unit of service is defined as a service period (accumulated contacts with the client, the client's family, significant others, and care providers) of fifteen minutes; partial units of time are rounded to the nearest quarter-hour increment. The unit of time serves as the basis for reimbursement for both Short-Doyle (State funds only) and SD/MC (State funds and FFP).

CASE MANAGEMENT RATES

Following is the methodology for computing the service rates for TCM services/regional center administrative costs.

Each regional center will utilize an average TCM unit of service rate.

1. The computation of the base rate is prospective and is established on the basis of historical costs.

   a. Determine the percentage of allowable time spent on TCM services by the appropriate direct service staff. Percentages will be determined based on a time study of each direct service classification.

   b. Multiply the percentages by the applicable costs for each classification. Costs will be obtained during each rate study period.

   c. Determine the percentage of allowable costs for all direct service classifications and multiply time the administrative/other staff costs and operating expenses. Costs will be obtained during each rate study period.

   d. Summarize all allowable costs and divide by the units recorded during the rate study period to arrive at a unit rate for TCM services/regional center administrative costs.

2. The rate will be re-based at least every three years. Rates will be indexed to the Consumer Price Index and adjusted in July of the years between rate studies.

3. Base recalculations will be conducted in May, with new rates effective the following July.

BILLING SYSTEMS

TCM services will be documented by the case manager on a Medicaid eligible, client specific activity log. See page 8 of this supplement which is an example of the documenting instrument to be employed by the CSC. The date of service, the case

manager providing the service, the units of service (recorded in 15-minute increments of service time), an explanation of the type of service, and the location of the service will be recorded on the activity logs. The total units of service provided to each Medicaid recipient eligible for TCM services will then be tallied at the end of each month by the regional center and submitted to DDS. A copy of the activity log will be retained in the client's record for auditing purposes.

DDS will prepare a computer tape which contains the Medicaid eligible's name, sex, date of birth, Medicaid identification number, social security number, the provider number (regional center), the month service was provided, and total units of service provided during the month. This tape will be run against the Single State Agency's [Department of Health Services (DHS)] master file of Medicaid eligibles. In California, this system is the Medi-Cal Eligibility Data System (MEDS).

An invoice will be prepared by DHS and submitted to the Federal Health Care Financing Administration for all regional center clients receiving TCM services who have been verified as Medicaid eligible (via computer match) for the month in which the service(s) was provided.

STATE OF CALIFORNIA -- DDS

CASE MANAGER CODE: 300 ATTACHMENT 1
CASE MANAGER NAME: WILLIAM PERRY

TARGETED CASE MANAGEMENT LOG
FOR THE MONTH OF JANUARY 1995

CLIENT NAME: JONES JOHN
CLIENT UCI: 4500201 CLIENT MEDI-CAL #:_____

DAY OF MONTH	ACTIVITY CODE	NUMBER OF UNITS	CLARIFICATION OF ACTIVITY CODE

TOTAL UNITS _____ SIGNATURE OF CASE MANAGER:_____

Reimbursement Methodology for Case Management Services as described in Supplements 1a, 1b, 1e and 1f to Attachment 3.1-A

1) Reimbursement rates shall be established for a specific unit of service. The unit of service shall be an encounter.

2) An encounter is defined as a face-to-face contact or a significant telephone contact in lieu of a face-to face contact when environmental considerations preclude a face-to-face encounter, for the purpose of rendering one or more TCM service components by a case manager.

3) A current year per encounter rate shall be established after evaluation of the total costs of providing case management services and the total number of encounters as reflected in the prior year cost report, defined by the department. The cost report shall accumulate allowable costs for the prior fiscal year, including both direct and indirect costs, as defined in OMB Circular A87.

   The per encounter rate is calculated by dividing the prior fiscal year costs of providing TCM services by the total number of encounters in that fiscal year. The per encounter rate is then multiplied by the projected number of encounters with Medicaid eligible persons to establish the total dollar amount that may be claimed in the current fiscal year.

   Total Medicaid reimbursement in the current year shall not exceed the product of:

   a. the projected number of Medicaid encounters for the current fiscal year; and
   b. the prior fiscal year costs of providing TCM services divided by the total number of encounters in that fiscal year.

   The costs associated with providing TCM services in the current fiscal year in excess of the total dollar amount for which reimbursement is made, are recognized in the cost report and become part of the calculation to determine the per encounter rate for the subsequent fiscal year.

4) Cost reports shall be due each year on or before November 1, for determination of the rate in the subsequent fiscal year. A certification statement, signed by a county-approved signator, shall accompany the cost report and attest to the validity and allowability of the cost data.

5) The department shall ensure "free care" and "third party liability" requirements are met.

6) The department shall conduct an annual survey of insurance carriers to determine whether TCM services, as described in this State Plan Amendment, are included and paid for as a covered benefit. The survey results will be used to determine the extent of Medicaid's payment liability in accordance with federal regulations set forth in 42 CFR 433.139(b).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: CALIFORNIA

Reimbursement Methodology for Case Management Services as described in Supplement 1c to Attachment 3.1-A

1) Providers participating in Targeted Case Management (TCM) will be required to submit a annual survey identifying:

   a. labor costs of performing TCM services; and
   b. overhead costs related to performing TCM.

2) The unit of service shall be a 15 minute case manager time increment on an individual beneficiary basis and billed through Electronic Data Systems (EDS).

3) Payments for TCM services will be issued by EDS directly to the providers of these services. The Department will work with EDS on:

   a. establishing and implementing the reimbursement process; and
   b. determining the appropriate edits and audits to ensure program integrity.

4) The department shall ensure "free care" and "third party liability" requirements are met.

5) The department shall conduct an annual survey of insurance carriers to determine whether TCM services, as described in this State Plan Amendment, are included and paid for as a covered benefit. The survey results will be used to determine the extent of Medicaid's payment liability in accordance with federal regulations set forth in 42 CFR 433.139(b).

6) Statewide hourly tiered rates will be established based on the annual survey submitted and will be grouped into low, medium, and high cost categories. Provider rates would be averaged for each of the 3 categories, providing the rate to be used by that grouping of providers.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: CALIFORNIA

Reimbursement Methodology for Case Management Services as described in Supplement 1d to Attachment 3.1-A

1) Reimbursement rates shall be established for a specific unit of service. The unit of service shall be an encounter.

2) An encounter is defined as a face-to-face encounter, or a significant telephone contact with or on behalf of the Medicaid eligible person, for the purpose of rendering one or more TCM service components by a case manager.

3) A current year per encounter rate shall be established after evaluation of the total costs of providing case management services and the total number of encounters as reflected in the prior year cost report, defined by the department. The cost report shall accumulate allowable costs for the prior fiscal year, including both direct and indirect costs, as defined in OMB Circular A87.

The per encounter rate is calculated by dividing the prior fiscal year costs of providing TCM services by the total number of encounters in that fiscal year. The per encounter rate is then multiplied by the projected number of encounters with Medicaid eligible persons to establish the total dollar amount that may be claimed in the current fiscal year.

Total Medicaid reimbursement in the current year shall not exceed the product of:

a. the projected number of Medicaid encounters for the current fiscal year; and
b. the prior fiscal year costs of providing TCM services divided by the total number of encounters in that fiscal year.

The costs associated with providing TCM services in the current fiscal year in excess of the total dollar amount for which reimbursement is made, are recognized in the cost report and become part of the calculation to determine the per encounter rate for the subsequent fiscal year.

4) Cost reports shall be due each year on or before November 1, for determination of the rate in the subsequent fiscal year. A certification statement, signed by a county-approved signator, shall accompany the cost report and attest to the validity and allowability of the cost data.

5) The department shall ensure "free care" and "third party liability" requirements are met.